-BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **STEPHEN MORRIS, M.D.** Holder of License No. **10800** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-01-0557 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Decree of Censure & Probation)

This matter was considered by the Arizona Medical Board ("Board") at its public meeting on October 3, 2002. Stephen Morris, M.D., ("Respondent") appeared before the Board with legal counsel Dan Jantsch for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 10800 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-01-0557 after receiving information from an anonymous source regarding Respondent's prescribing of controlled substances to a female patient ("IS"). The Board's investigation revealed that in 2001 Respondent had written 65 prescriptions totalling 6,198 dosage units of Oxycodone to IS. The prescriptions were issued using variations of both IS's name and other identifying information and were filled at pharmacies in both Arizona and California.

4. At the formal interview Respondent testified that he had been practicing medicine for approximately 29 years and that in his private practice he basically treats

patients who have anxiety disorders and depressive disorders. Respondent stated that he was also a staff psychiatrist for Value Options, a privately run company that is contracted with the State to provide care for the seriously mentally ill in Maricopa County.

5. Respondent testified that IS's case was complicated and that he very much regretted the situation. According to Respondent, he began treating IS after she called him to set an appointment and related to him that she was depressed and being treated for pain due to an automobile accident. IS indicated that she believed the pain was contributing to her depression. Respondent testified that he first saw IS approximately two or three weeks after first having spoken to her on the phone. Respondent stated that IS was divorced, had two small children, and presented in a timely fashion and was well groomed at the first appointment. According to Respondent, IS was being treated with methadone for her pain and she asked him to help her get off the methadone. Respondent indicated that he believed that the two things that "threw him off the track" of detecting that IS was a problem patient were her presentation at his private practice and her presentation as a well-groomed housewife.

6. Respondent testified that his first erroneous decision was to attempt to get IS off the methadone. Respondent stated that the plan was for IS to obtain a second consult from an orthopedic surgeon who would treat her for her pain problem after Respondent withdrew her from the Methadone and began treating her for depression. Respondent stated that it was an error on his part to not check with any of IS's prior treating physicians and get her records. Respondent stated that if IS presented today he would immediately refer her to a pain specialist.

7. Respondent was asked why he did not refer IS to a pain specialist and why he prescribed what appeared to be a tremendous amount of medication. Respondent stated that initially things went well with IS and she was on less and less Methadone (10

milligrams from 60) and was doing well over a period of about two months. Respondent stated that IS then began to complain of pain in her neck from the automobile accident and he prescribed 20 Percocet. Respondent testified that IS called him three or four days after he prescribed the Percocet and said they were all used up. Respondent testified that IS told him that she lost her job, her insurance, and her apartment and had to move to California to live with her brother. Respondent testified that he believed he had a responsibility to see that IS received treatment even though she repeatedly told him she could not afford to see anyone else. Respondent stated that he continued to attempt to prescribe less and less doses of the pain medication, but being a psychiatrist he was aware of the potential for suicide and tried to space the medication and make it a little more difficult for IS to get. Respondent testified that IS eventually was kicked out of her brother's home and ended up in a trailer park.

8. Respondent was asked about his writing prescriptions for IS using different names. Respondent testified that he used different names because IS told him she had different names. According to Respondent IS told him that "I" was not her first name, but another name somewhat related to "I" and that in while in San Diego she used a name that she said her family referred to her by. Respondent was also asked about using Federal Express to send IS her prescriptions. Respondent stated that using Federal Express is not normal practice.

9. Respondent's attention was drawn to a February 19, 2001 note in IS's chart stating "Patient clearly has an addiction problem." Respondent was asked why he continued to prescribe large amounts of pain medication for approximately eight more months to a patient whom he believed had an addiction problem. Respondent stated that what he should have done was referred IS to a methadone clinic.

10. Respondent was asked why he eventually terminated his treatment relationship with IS. Respondent testified that he called the medical records departments of two hospitals at which IS claimed to have been treated and was told there were no records to validate her claims. Respondent stated that at that point IS had also "no-showed" him four times in a row. Respondent stated that he was aware that IS's health insurance would be becoming effective in a short period and he was confident that she could find another treating physician. Respondent also stated that he received a phone call from a pharmacy inquiring about a prescription for IS and when the pharmacy faxed the prescription he saw that IS had forged his signature. Respondent stated that all these factors led him to close IS's case.

11. Respondent testified that in February 2002 he took a course in prescribing to help him better identify problem drug-seeking patients.

12. The applicable standard of care would require a treating psychiatrist to have the pain records to justify the chronic use of narcotics and, if the psychiatrist undertakes to treat a patient for withdrawal, that there be a pain contract.

13. Respondent's conduct was unreasonable in that, given the standard of care, he did not obtain IS's pain records and did not enter a pain contract with IS when he began to treat her for withdrawal.

14. There was potential harm to IS because her ongoing dependency was maintained.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances above in paragraphs 3, 6, 8 and 12 through 14 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(j) ("[p]rescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes;") and 32-1401(24)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that:

1. Respondent is issued a Decree of Censure for improper prescribing of excessive amounts of controlled substances and failure to perform an adequate evaluation of a patient's condition.

2. Respondent is placed on Probation for one year with the following terms and conditions:

(a) Respondent shall within one year of the effective date of this Order, obtain 20 hours of Board staff pre-approved Category I Continuing Medical Education (CME) in medical ethics to include boundary issues. Respondent is to provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of Respondent's medical license.

(b) Respondent shall be subject to a pharmacy chart review within one year of the effective date of this Order. The Board retains jurisdiction to take additional disciplinary action based on the results of the chart review.

(c) Respondent shall pay the costs associated with monitoring his probation as designated by the Board each and every year of probation. Such costs may be adjusted on an annual basis. Costs are payable to the Board no later than 60 days after the effective date of this Order and thereafter on an annual basis. Failure to pay these costs within 30 days of the due date constitutes a violation of probation.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that she has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 4th day of December, 2002.

ARIZONA MEDICAL BOARD

BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 5th day of December, 2002 with:

The Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
5th day of December, 2002, to:

Dan Jantsch
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Executed copy of the foregoing
mailed by U.S. Mail this
5th day of December, 2002, to:

Stephen Morris, M.D.
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Copy of the foregoing hand-delivered this
5th day of December, 2002, to:

Christine Cassetta
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